

304.17A-600 Definitions for KRS 304.17A-600 to 304.17A-633. (Effective January 1, 2023)

As used in KRS 304.17A-600 to 304.17A-633:

- (1) (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:
 1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
 2. Benefit coverage is therefore denied, reduced, or terminated.
- (b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;
- (2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions;
- (3) "Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay;
- (4) "Covered person" means a person covered under a health benefit plan;
- (5) "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in KRS 304.17A-623, 304.17A-625, and 304.17A-627;
- (6) "Health benefit plan" has the same meaning as in KRS 304.17A-005, except that for purposes of KRS 304.17A-600 to 304.17A-633, the term includes short-term coverage policies;
- (7) "Independent review entity" means an individual or organization certified by the department to perform external reviews under KRS 304.17A-623, 304.17A-625, and 304.17A-627;
- (8) "Insurer" means any of the following entities authorized to issue health benefit plans as defined in subsection (6) of this section: an insurance company, health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association; nonprofit hospital, medical-surgical, or health service corporation; or any other entity authorized to transact health insurance business in Kentucky;
- (9) "Internal appeals process" means a formal process, as set forth in KRS 304.17A-617, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent;
- (10) "Nationally recognized accreditation organization":
 - (a) Means a private nonprofit entity that:
 1. Sets national utilization review and internal appeal standards; and

2. Conducts review of insurers, agents, or independent review entities for the purpose of accreditation or certification; and
 - (b) Shall include the Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), the American Accreditation Health Care Commission (URAC), the Joint Commission, or any other organization identified by the department;
- (11) "Private review agent" or "agent":
- (a) Means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth; and
 - (b) Does not include an independent review entity which performs external review of adverse determinations;
- (12) "Prospective review" means a utilization review that is conducted prior to the provision of health care services. "Prospective review" also includes any insurer's or agent's requirement that a covered person or provider notify the insurer or agent prior to providing a health care service, including but not limited to prior authorization, step therapy protocol, preadmission review, pretreatment review, utilization, and case management;
- (13) "Qualified personnel" means licensed physician, registered nurse, licensed practical nurse, medical records technician, or other licensed medical personnel who through training and experience shall render consistent decisions based on the review criteria;
- (14) "Registration" means an authorization issued by the department to an insurer or a private review agent to conduct utilization review;
- (15) "Retrospective review":
- (a) Means utilization review that is conducted after health care services have been provided to a covered person; and
 - (b) Does not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment;
- (16) (a) "Urgent health care services" means health care or treatment with respect to which the application of the time periods for making nonurgent determination:
1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
 2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.
- (b) Urgent health care services include all requests for hospitalization and outpatient surgery;
- (17) "Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective

review; and

- (18) "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

Effective: January 1, 2023

History: Amended 2022 Ky. Acts ch. 19, sec. 5, effective January 1, 2023. -- Amended 2019 Ky. Acts ch. 190, sec. 7, effective January 1, 2020. -- Amended 2017 Ky. Acts ch. 80, sec. 56, effective June 29, 2017. -- Amended 2015 Ky. Acts ch. 9, sec. 7, effective June 24, 2015. -- Amended 2010 Ky. Acts ch. 24, sec. 1235, effective July 15, 2010. -- Amended 2004 Ky. Acts ch. 59, sec. 11, effective July 13, 2004. -- Amended 2002 Ky. Acts ch. 181, sec. 4, effective July 15, 2002. -- Created 2000 Ky. Acts ch. 262, sec. 1, effective July 14, 2000.

Legislative Research Commission Note (1/1/2023). 2022 Ky. Acts ch. 19, sec. 13, provides that the amendments made to this statute shall apply to health plans delivered, issued for delivery, or renewed on or after January 1, 2023.